Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004718	A. BUILDING _____ B. WING _____	10/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARGARET MARY COMMUNITY HOSPITAL INC	321 MITCHELL AVE BATESVILLE, IN 47006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for the investigation of a licensure complaint. Survey Type: Licensure complaint IN00083194 Unsubstantiated, lack of sufficient evidence. Date of Survey: 10-06 -11 Facility number: 004718 Surveyors: John Lee, R.N. Public Health Nurse Surveyor Margaret Mary Community Hospital Inc is in compliance with 410 IAC 15-1.5-5, Medical staff, 410 IAC 15-1.5-6, Nursing services, and 410 IAC 15-1.6-2, Emergency services. QA: claughlin 10/14/11	S 000		